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THE INTERNATIONAL PELVIC PAIN SOCIETY

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In This Issue

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The President's Perspective

Richard P. Marvel, MD
If You Build It They Will Come

In the last President's Perspective, I covered some ideas on the patient's perspective and some do's and don'ts in the general approach to these patients. For those of you that may be interested in pelvic pain as a focus of practice, it may seem to be an overwhelming task. How in the world can you see more than one patient with chronic pelvic pain a day? How can you stand it? How can you possibly help these complicated patients? Why bother?

The answers to these questions are likely different for different practitioners. There are no universally correct answers, but there are some general concepts that likely are similar among different pelvic pain specialists. While I can't speak for everyone, it is challenging, rewarding, and there are few people who can. It can give someone a niche that can be developed to separate you from the masses. I will highlight some of the ways to develop, organize and manage things to make it a success.

First, it is a journey. It is not something you can learn in a weekend. It takes a clinician that has a desire to continue learning and adapting throughout their career. You have to have a certain passion or drive to figure out what is going on with a certain patient. When you take the time to learn about a new presentation or disorder, you will be amazed at how often you will come across it in the future. You truly do learn new things from almost every patient you evaluate. There are several excellent texts to get you started. There are a few fellowships that give you an excellent start. But no matter how you start, you have to be dedicated to a life of learning new things. Start with the diagnosis and management of the most common pelvic pain disorders; you will immediately be well ahead of the average clinician. Review the evaluation and management of endometriosis, interstitial cystitis, irritable bowel syndrome, pelvic congestion, myofascial pain, peripheral neuropathy and pelvic floor myalgia. Master the physical exam recommended in Dr. Howard's book, *Pelvic Pain: Diagnosis and Management*. If possible, spend several days with some of the veterans of the pelvic pain field. While those days cannot teach you everything, it will give you insight into how to approach the patient. Keep in mind, even the experts don't agree on everything. With persistence, practice and continued self-education, you will be amazed at the progress you will make.

Organization of the process can tremendously streamline patient flow. I have one of my office staff review and summarize the medical records and the pelvic pain forms, available on the website www.pelvicpain.org, which the patients are required to return prior to getting an appointment. By reviewing this information, a pain map, and composing a problem list, you can generally narrow down the likely diagnoses. With practice, you will know what most patients have before you see them.

I generally start by asking the patient when their pain first started, and how it evolved over time. If you listen, they will generally tell you what is wrong. They will give you most of the information you need to know to figure out the components of their pain without interrupting them. Of course, some patients need to be directed and focused more than others. Many times you may want to stop to ask a specific additional question that is related, but for the most part let them tell their story. I use a ROS form that patients fill out on arrival that can be reviewed quickly. The past history, surgical history, social and family history is obtained by the forms. In my case, it is entered into my EMR prior to their appointment. Important aspects can be reviewed quickly. I spend the majority of time getting the history, physical exam and counseling.

Patients are seen on a regular basis, generally on a monthly basis. They are counseled that, with treatment, they will improve over time. All management decisions are made in the office. Only emergencies or significant side-effects are managed by phone. We try to implement multimodal therapy upon diagnosis to get them to improve and get results quickly. Once they have improved, you can build on this over time. Just outlining the components they have is very helpful. I get very few phone calls outside of office hours.

In some ways, a pelvic pain practice is similar to an oncology practice. Most notably, you can't save them all, but the ones you do will be eternally grateful. You will have a tremendous effect not only on their life, but also the lives of those close to them. Medical therapy is almost always necessary, with surgical interventions when indicated. There are a variety of disorders involved each with unique treatments. It takes time, improvement or cures are usually not immediate. The focus is always on improving function, restoring their lift back to normal with as much pain relief as possible. Even the most severely affected individuals can generally have success. It can be very rewarding.

Almost everything I do on a daily basis, with the exception of endometriosis, I learned after my formal training. Work with and learn from your colleagues: general surgeons, urologists, physical therapists, and interventional pain physicians. Each skill you learn will benefit not only you, but also many patients in the future. You will steadily build your practice. Get the message out that this is an interest you have. If you build it, they will come. The more patients you help, the more patients will come. It is not for everyone, you have to be able to leave it at the office when you go home. Good luck, and accept the challenge.

Message from the 2010 Fall Program Co-Chairs

Georgine Lamvu, MD, MPH, FACOG
Frank Tu, MD, MPH

Chicago's Palmer House Hilton provided a charming lakeside venue for the 18th Annual Meeting of the IPPS. In a Lincolnesque performance, IPPS President Dr. Richard Marvel kicked off the meeting with a historical survey of the society's progress. Our two memorial speakers (neuroscientist Dr. Peggy Mason spoke as the James E. Carter Memorial Lecturer, and plastic surgeon Dr. A. Lee Dellon gave the C. Paul Perry Memorial Lecture) gave two inspiring talks that showed just how complicated the field of pelvic pain is -- Dr. Mason on brainstem mechanisms in visceral pain, and Dr. Dellon on his vast experience in peripheral nerve decompression for pain.

The scientific meeting program covered just about everything in between these two bookend speakers, including a self-help symptom management program for IBS, new hormonal advances in endometriosis management, neuromodulation for PBS/IC, and the role of early neonatal trauma in the development of pelvic pain. The strong emphasis on manual therapy approaches was highlighted by talks on the latest clinical trial evidence supporting physical therapy for PBS/IC, and an exploration into the roles of hip pathology, connective tissue, and neural tension in pelvic pain disorders.

Once again, we were blessed to have several experts from the NIDDK-funded Multidisciplinary Approach to Pelvic Pain network sites -- Drs. J. Quentin Clemens, David Klumpp, A. Vania Apkarian, and Laurie Keefer offered significant insights into the challenges of studying and treating visceral pain in the gut and bladder.

IPPS unveiled it's first-ever Basics Course, and it could not have been done without the volunteer contributions of so many IPPS members. The high turnout for this pre-congress workshop confirmed the continued need for high quality lectures on the fundamentals of managing pelvic pain. Special thanks go out to Drs. Howard Sharp, Suzie As-Sanie, and Sarah Fox for their always illuminating and insightful lectures.

The poster session was well-attended and two posters were selected by a panel of judges for the Best Poster Award.

The Physical Therapy Course was, as usual, very well-attended. This year's course, "An Introduction to Visceral Manipulation," was presented by Dee Hartmann, DPT, who provided an extremely informative and practical look at anatomy, physiology, and principles of visceral manipulation and its use in patients with chronic pelvic pain. The course was held at the Rehabilitation Institute of Chicago, and we're very grateful to all those from RIC who were indispensible in setting this up, especially Dr. Colleen Fitzgerald and Suzanne Badillo, PT, WCS. We also want to recognize Amy Stein, MPT and Stephanie Prendergast, MPT for their invaluable help in the planning of not only this course but the entire Fall Meeting.

SAVE THE DATES!

2011 IPPS Spring International Scientific Meeting
May 26 - 29, 2011

Ceylan Intercontinental Hotel
Istanbul, Turkey
www.ipps2011.org

19th Annual IPPS Meeting
October 20 - 22, 2011
Las Vegas, Nevada
More details coming soon to www.pelvicpain.org!

2010 IPPS Annual Meeting - Poster Abstract Winners

PRIOR ORAL CONTRACEPTIVE USE IS ASSOCIATED WITH RISK OF ENDOMETRIOSIS CONDITIONAL ON PARITY: RESULTS FROM A LONGITUDINAL, POPULATION-BASED SURVEY

Frank Tu, MD, MPH (1); Gregory Goldstein (2); Hongyan Du, MPH (1); Sangeeta Senapati, MD, MS (1); Kristen Pozolo (1)
(1) NorthShore Health; (2) Tufts University
Presented By: Frank Tu, MD, MPH

Objective: Determine whether prior OCP use is protective against future development of endometriosis in previously healthy women.
Methods: We conducted a retrospective cohort study of OCP users and nonusers in the Australian Longitudinal Study on Women's Health (ALSWH), which prospectively follows 40,000 women over a 20 year period, to better estimate the association between OCP use and risk of endometriosis. Data was analyzed from the young woman subset (n=9427, age 18−23 at entry) at four survey time points (1996, 2000, 2003, and 2006). Confounders and effect modifiers were determined by extensive review of the literature and bivariable analyses. We estimated the risk of endometriosis after OCP exposure using a Cox proportional hazards (PH) regression with time−dependent covariates and adjusted for previously identified and post−hoc confounders found through statistical modeling. The risk window for OCP exposure was based on self−report from the epoch prior to that in which the diagnosis of endometriosis was made.
Results: A total of 514 new endometriosis cases occurred over the 10 years, with an incidence rate of 670/100,000 person-years of risk. The final multivariable Cox PH regression model included BMI, parity, geographical location, OCP use for other reason, urinary pain, marital status, SF−36 pain score, dysmenorrhea, total years of OCP use and its interaction with parity. Nulliparous women with a history of < 5 years (or ≥ 5 years) of prior OCP use had a 1.8 (or 2.3) times higher risk for subsequent diagnosis of endometriosis (hazard ratio [HR] 1.81, 95% CI [1.30−2.53] and 2.32 [1.58−3.40], respectively). Parous women with 5 years or more (or <5 years) exposure had 59% (55%) reduced risk (HR 0.41, 95% CI [0.15−0.56] and 0.45 (0.16−1.23], respectively) compared to those who never used OCPs. Among nulliparous women, prior exposure to OCPs appear to have a dose−dependent increased risk of developing endometriosis, while among parous women, prior exposure to OCPs was protective. In addition, parity was a risk for endometriosis among women who never used OCP, but a protector among women with OCP use >5 years.
Conclusions: While our study revealed that longer OCP use plus parity were protective against endometriosis, rigorous mechanistic studies are needed to validate if use of exogenous sex hormones are a risk factor for development of endometriosis and pelvic pain conditions among nulliparous women.
Summary: We found that prior use of OCPs among nulliparous women in

a prospective longitudinal study of young Australian women is associated with higher risk of developing endometriosis.
Key Words: endometriosis, epidemiology, risk factor, oral contraceptives

MYOFASCIAL ABDOMINAL AND PELVIC MUSCLE PAIN COMPLICATES CHRONIC PELVIC PAIN
Bradford Fenton, MD PhD
Presented By: Bradford Fenton, MD, PhD

Objective: Chronic pelvic pain syndrome includes several pain conditions arising from the visceral organs of the pelvis, but may also include pain and tenderness of the muscles in the anterior abdominal wall and pelvic floor. Although they may occur separately, it is possible that pain and tenderness of the muscles in the anterior abdominal wall (MFPS) and pelvic floor (PFTM) together can be thought of as a combined pelvic muscle pain disorder: myofascial abdominal and pelvic pain (MAPP). It is unknown if the presence of MAPP worsens standard pain measures, or if it is related to other pain risk factors.
Methods: 149 consecutive patients referred to a pelvic pain specialty center underwent standardized quality of life testing using the NIH PROMIS system and had both visceral and myofascial pain diagnoses assigned on the basis of physical exam evoked tenderness and pain pressure threshold algometry. PROMIS measures (global mental, global physical, pain behavior, pain impact, and physical function) were compared between diagnostic groups.
Results: MFPS was present in 54% of patients; PFTM was present in 50% of patients; and the combination of both (MAPP) was present in 32% of patients. Global physical and Global Mental scores were worse when MAPP occurred either when evaluated as a separate diagnosis, or with other CPP related diagnoses ($p<0.005$). Pain behavior and pain impact scores were worse depending on the underlying diagnosis. Physical function was worse when MAPP occurred, especially in IC and IBS ($p<0.005$).
Conclusion: The co-occurrence of MAPP in other CPP diagnoses worsens several quality of life domains, suggesting that this may be an unrecognized component of CPP symptoms. Central pain sensitization and motor area activation can be postulated to contribute to the development of MAPP in CPP.
Summary: Myofascial abdominal and pelvic floor pain often complicates CPP, and when both occur symptoms are worse.

2010 Speaker PowerPoint Presentations

Visit the IPPS website, www.pelvicpain.org to view PowerPoint slide presentations from the 2010 IPPS Annual Meeting

On the IPPS homepage, scroll down to Scientific Meeting Presentations, and click View available 2010 presentations

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Call for IPPS VISION E-Newsletter Contributions

If you wish to contribute an article or column to the newsletter, would like to submit information regarding job prospects, pelvic pain announcements or have comments about the newsletter, please email Lisa Oesterreicher at lisao@wjweiser.com.

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